Guidelines

Personal Health Information

PURPOSE

This policy clarifies the requirements for Registrants to be in compliance with the Personal Information Protection and Electronic Documents Act (PIPEDA) and the Personal Health Information Act (PHIA) for the collection, use, retention and disclosure of personal information in any form, including financial, medical, computer data storage, hard copies, and other records by all Registrants. To review the Act click here: http://web2.gov.mb.ca/laws/statutes/ccsm/p033-5e.php

APPLICABILITY

This policy applies to all Members of the Manitoba Naturopathic Association including their staff.

PROCEDURES

1. All members are required to set up policies and procedures regarding the collection, use, retention and disclosure of personal information such that they are in compliance with the Personal Information Protection and Electronic Documents Act (PIPEDA) and the Personal Health Information Act (PHIA). All new members will be given a package of template documents created for the Members of the Manitoba Naturopathic Association to assist them with becoming compliant with PIPEDA and PHIA, along with contact information for how they can further develop those documents to fit their individual clinical situations.

2. An appointment book, electronic or written, must be kept and retained for a period of at least ten (10) years, which clearly and legibly identifies the date, patient name and type of service scheduled.

3. Separate patient financial records shall be kept for naturopathic services provided, either as a written record or as a computerized file. Financial records must contain the date of service, payment received from all sources, and balance of accounts to date. The patient's name, address, and telephone numbers shall be permanently inscribed on this record.

4. Each patient shall be given an itemized receipt for each visit where naturopathic services were provided. Such a receipt shall include all services related to naturopathic treatments, as well as the practitioner's name and registration number.

5. Separate health records shall be kept for naturopathic services, either as a written record or as a computerized file. Health records will include:

(a) the patient's name, address, telephone number, date of birth, and sex
(b) all office consultations, telephone consultations, examinations, treatment and progress notes, including the date, and the name of the patient on each page;
(c) chief complaints and secondary complaints, relevant medical history, diagnostic tests, and relevant physical exam findings;
(d) assessment;
(e) referrals to outside doctors and/or health care providers, and
(f) treatment plan.

6. It is recommended by the Board that a signed Consent to Diagnose and Treat form be kept in the file.

7. All records noted herein for both active and inactive patients, shall be retained for ten (10) years. For computerized records, it is necessary to keep copies on separate diskettes or back-up tapes in a safe place for ten (10) years.

8. Patient files for minors must be retained by the Registrant for ten (10) years following the client's 18th birthday, regardless of the date of the last visit. For example,if a child last saw you when she was 5 years old, you are responsible for keeping that file for 10 years past the child's 18th birthday, or for a total of 23 years beyond the date of the last visit.

9. A patient will be deemed to be an "inactive" patient when:
a) her/his treatment is completed; or
b) the registrant or patient has indicated that the patient will no longer be an active patient.
c) files for all adult clients must be retained for 7 years following the date of their last visit.

10. Patients, or their legal representatives, are entitled to copies of the patient files, however, the Registrant must always maintain the original files unless requested by the Board during the investigation of a complaint.

11. In the event of the death of the registrant, the responsibility for the maintenance of the records rests with the estate, which is obliged to maintain those records as above. In the event the estate sells the practice to another registrant, those original records are transferred to that registrant, and must be maintained as above. It is the responsibility of each registrant to ensure that there is an orderly preservation of the patient files arranged in the event of her/his death. It is also the responsibility of the registrant to ensure that in the event of her/his death, their legal representative will notify the Board immediately.

12. If the registrant moves out of town, province, or country, and closes her/his practice and does not sell it to anyone else, s/he must maintain the original of all patient files for the ten (10) year minimum.

13. If the registrant sells her/his practice, all of the original records are transferred to the Registrant who is purchasing the practice who will maintain those records as set out above. All patients, and this Board, must be notified that the practice is being sold so that any patient who requires copies of her/his record can obtain them. The Board must be notified of the sale and in whose care and control the original records will be maintained and preserved.

14. If the Registrant retires, or closes her/his practice and does not sell it to anyone else, s/he must maintain the original of all patient files for the ten (10) year minimum. The Board must be notified of such retirement or cessation of practice, and be provided with a forwarding address for a minimum of ten (10) years.

15. In the event of a share practice/partnership/associateship practice, by the terms of the written agreement which must be made between the registrants, the patient files are either the responsibility of the registrant or the primary registrant of the practice. All patients must be made aware that other practitioners may have access to their patient file. The patient can then decide if s/he wishes to have another practitioner have access to her/his file.

16. In all cases, a forwarding address of where the records are available must be provided to the Board for a minimum of ten (10) years from the date of the last day of practice of the registrant.

17. Files must be destroyed by shredding or other manner to render them illegible.

18. It is a recommendation of this Board that, prior to destroying the files after the ten (10) year period, the patient be contacted to determine if they would like to have the file.